

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-017103

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

318  
FILED MAY 10 1962

1003

4651

VS 300  
Rev. 4/59

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4007.3

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USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY <i>St. Louis</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		c. CITY OR TOWN <i>Webster Groves</i>	
Length of stay in 1b <i>2 months</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>Deaconess Hospital</i>		d. STREET ADDRESS (If outside, give location) <i>224 Simmons Ave.</i>	
3. NAME OF DECEASED (Type or print) First <i>Martha</i> Middle <i>Jane</i> Last <i>Musick</i>		4. DATE OF DEATH Month <i>May</i> Day <i>6</i> Year <i>1962</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>3-9-17</i>
9. AGE (last birthday) <i>45</i>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>self</i>	
11. BIRTHPLACE (City and state or country) <i>Union City, Tennessee</i>		12. CITIZEN OF WHAT COUNTRY <i>U. S. A.</i>	
13a. FATHER'S NAME <i>Clarence E. Carter</i>		13b. MOTHER'S MAIDEN NAME <i>Georgia Lillian Haley</i>	
14. NAME OF HUSBAND OR WIFE <i>Howard T. Musick</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Howard T. Musick 224 Simmons</i>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of ovary</i>		INTERVAL BETWEEN ONSET AND DEATH <i>6 mo.</i>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>175.0</i> DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <i>9:18</i> a.m. Month, Day, Year <i>6.1</i>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <i>9.18.61</i> to <i>5.4.62</i> and last saw her/him alive on <i>5.4.62</i>		Death occurred at <i>3:30 a.m.</i> on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <i>Frederick Martin M.D.</i>		22b. ADDRESS <i>950 James Place</i>	
22c. DATE SIGNED <i>5.7.62</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>	23b. DATE <i>5-8-62</i>	23c. LOCATION (City, town, or county) (State) <i>Columbia, Missouri</i>	
24. FUNERAL DIRECTOR <i>WOLBERG - GERBERS</i>		25. DATE RECD. BY LOCAL REG. <i>MAY 7 1962</i>	
26. COLONIAL CHAPEL		27. REGISTRAR'S SIGNATURE <i>Earl Smith. M.D.</i>	

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Stanley H. Lipson  
Licensed Embalmer No. 4193

P. O. Address S. L.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.